RESET

**Claims Section**
**Department of Labor and Industries**
**PO Box 44291**
**Olympia WA 98504-4291**

# AUTHORIZATION TO RELEASE CLAIM INFORMATION

**(to be completed by the worker**

Claim No.

***This form must be completed in full***

**I, _____ , designate the following individual as my authorized representative.**

_____
**Name of authorized representative (please print))**

Phone number
( )

Address

City State ZIP +4

***Please check the proper box(s).***

☐ I am authorizing the release of my claim file to the authorized representative named above for review.

☐ I am authorizing the mailing of my claim file, checks & correspondence from this date forward to the authorized representative's address listed above.

☐ I am authorizing, but limit the release of information (to the authorized representative) from my claim file to the following: (*for example, "all non-medical records", "the panel exam of Feb 4, 1977", etc.): please list limitations below.*

☐ I am authorizing the release of information regarding sexually transmitted disease (STD), if any, as defined by state law.

**This authorization will remain in effect UNTIL REVOKED IN WRITING by the claimant.**

| Date | Phone number ( ) | Worker's address |
|---|---|---|
| City | State ZIP | Worker's Signature |